

**“BECAUSE LIFE IS SHITTY”: RECONSIDERING SUICIDAL DISTRESS AND  
IMAGINING HUMANIZING RESPONSES**

“BECAUSE LIFE IS SHITTY”: RECONSIDERING SUICIDAL DISTRESS AND  
IMAGINING HUMANIZING RESPONSES

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AMY RECTOR, B.S.W.

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AUTHOR: Amy Rector, B.S.W (York University)

SUPERVISOR: Dr. Ameil Joseph

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## **Abstract**

*Background:* Current social service prevention and interventions in suicidal distress follow a biomedical logic. Recently, critical suicidology and mad studies frameworks have criticized this single-fold approach for limiting the capacity of suicide prevention/intervention to respond to the range of human needs.

*Aims:* The aim of this study was to uncover how people with history of suicidal distress understood their experience of distress, in particular the responses they find helpful and unhelpful.

*Methods:* 4 participants were recruited for semi-structured interviews themed for conceptions of suicidal distress, the experience of ‘reaching out’, and mental health systems change.

*Results:* The findings concluded that participants’ conception of suicidal distress differs from biomedical model paradigms. While practitioner’s responses rely on a notion of suicidal distress as discreet and de-contextual, participants explained suicidal distress as ongoing and based in life circumstances, advocating for a model of suicidal prevention/intervention highlighting the importance of relationships and empathy.

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## **Introduction**

In 2012, 14% of Canadians aged 15-25 had experienced suicidal thoughts in their lifetime (Statistics Canada, 2015). Unfortunately, these statistics are not uncommon and instead represent a consistent social problem in Canada. In response to this social concern, mental health workers across various disciplines in psychology, psychiatry, and social work participate in an array of crisis and suicide prevention and intervention work with people in distress. However, in recent years these forms of prevention and intervention have come under scrutiny by critical researchers and consumer/survivors who advocate for more in-depth, nuanced, and complicated understandings of both the nature of suicidal distress and the most compassionate, caring, and appropriate responses to it (White, Marsh, Kral & Morris, 2016; Shaw, 2016; Webb, 2016; Marsh, 2016). Sadly, instead the knowledge available to practitioners is, on the whole, limited and uniform, following a basically medical viewpoint (Marsh, 2016).

Dominant models of suicidality utilized in health care and social services today follow a strictly medical model understanding. This medical viewpoint sees suicide as pathological and individual (Marsh, 2016). Suicide is understood primarily as an individual crisis, in which a person's capacity to cope is overwhelmed by a traumatic or stressful event (Lewis & Roberts, 2001). Moreover, within this framework social service and health care workers are assumed to have the ability to both predict and thus prevent suicides (Lewis & Roberts, 2001). To carry this out, social service and health care workers use assessments which are thought to accurately identify suicidality and lethality, to determine what degree of intervention a worker must initiate. According to Lewis and Roberts (2001), the importance of an assessment lies in its ability to quantify the magnitude of a person's crisis. Apparently, when the magnitude can be scientifically

and accurately determined, clinicians will be able to better predict suicidality and therefore provide the best treatment (Lewis and Roberts, 2001).

This discourse of suicide begets some material results. For example, many suicide prevention programs have turned to focusing on limiting access to means, since this has been shown to be the most effective way to prevent death by suicide (World Health Organization, 2014). These sorts of interventions include suicide rails in subways and barriers to bridges, buildings, and other tall structures (Beautrais, 2007; Mishara, 2007). Additionally, this individualized approach has given disproportional weight to positivist research concerns such as protective and worsening factors (World Health Organization, 2014) and demographic data (Leenaars & Lesters, 2004). Thus, the trajectory of both research and application of results under this medical, pathological, and individual framework has been a reification of suicide prevention work that concentrates on lethality using methods that do not account for individual feelings or lived experience.

To address this gap in the literature, theorists and researchers in studies of suicidality and suicidology have raised concerns about this limited query into suicidal behaviour. For example, Bergmans, Rowe, Dineen, and Johnson (2016) question the lack of attention that has been given to the concept of human connection and compassion in the research on suicide prevention. Given that studies show that the relationship between client and caregiver is one of the most important aspects of the recovery process for clients (Agar-Jacomb & Read, 2009; Hughes, Hayward & Finlay, 2009; Trevithick, 2014), it is notable that current suicidology lacks a significant understanding of this relevant factor. Moreover, within this climate, valuable questions about distress, suffering, healing, and meaning are left both unquestioned and seemingly unimportant (White, Marsh, Kral & Morris, 2016).



Research in other areas has also addressed the lack of consumer/survivor input in both theorizing suicidality and evaluating the effectiveness of current interventions (White, Marsh, Kral & Morris, 2016; Hjelmeland, 2016). This research has shown that centering the voices of consumer/survivors allows for a better comprehension of suicidal feelings and acts as well as better responses to distress (Shaw, 2016; Webb, 2016; Hjelmeland, 2016; LeFrancios, 2016; Agar-Jacomb & Read, 2009). In fact, through reflecting on lived experience, some authors have proposed alternative responses to distress which challenge the simplistic and narrow thinking in mainstream suicide prevention services (Webb, 2016; Mead & Filson, 2016; Starkman, 2013) encouraging a broader and more complex understanding of care.

In light of these significant gaps in mainstream suicidology research, this thesis aims to build on recent recognition of the importance of moving beyond objective, positivist, individualist, decontextualized, and depoliticized suicide research (White, Marsh, Kral & Morris, 2016) to imagine how studies of suicide can embody a different discourse- one in which questions of lived experience and human connection are deemed crucial. To do so, this thesis builds on recent research which centers the voices of people who use mental health and suicide prevention services. Therefore, this thesis asks, “What are people looking/hoping for when they ‘reach out for help’?” and “what kinds of responses do people want?”, in the attempt to pave the way to imagine a model which accounts for peoples’ expressed needs. Inherent in this question is an interrogation of current models of suicide prevention and an attempt to display the discrepancies between people’s lives and mental health responses. In this way, this thesis aims for a critique of biomedically-based suicide prevention services, instead working to center both the experiences of people with histories of suicidal distress and their knowledge about mental health social change.

## **Literature Review**

Between the academic fields of sociology, social work, nursing, psychology, mental health, and Mad studies there exists a broad range of diverse knowledges and approaches regarding the causes and treatment of suicidal distress. In aiming to understand individuals' experience of 'reaching out', the spectrum of various responses can be a useful frame. While research on suicide and suicide prevention is vast, by providing an overview of the effectiveness of current suicide prevention interventions, the most appropriate locus of intervention, and the relevance of lived experience in shaping theory and practice, I situate the research findings within the boundaries of current tensions and debates in practice.

### **Effectiveness of Current Interventions**

Current suicide prevention initiatives range from the local, individual-level interventions to global initiatives aimed at creating large-scale structural responses. Prevention efforts aimed at the individual tend to include hospitalization, telephone helplines, and the administering of suicide assessment measures by trained mental health staff and 'community gatekeepers' (Canadian Association of Mental Health, 2013; Coveney, Pollock, Armstrong & Moore, 2012; Leenaars & Wenckstern, 1999; White & Stoneman, 2012). These efforts center around assisting individuals to cope with immediate crisis as well as securing their transfer to the hospital if immediate lethal threat is a concern. Other suicide prevention efforts target the structural or societal level of response and include suicide awareness strategies and screening programs (White & Stoneman, 2012). Relevant to this level of intervention is the World Health Organization's "Preventing Suicide" report (2014), which lists the appropriate national-scale suicide responses as "surveillance, means restrictions, media guidelines, stigma reduction and raising of public

awareness as well as training for health workers, educators, police and other gatekeepers” (Executive Summary, p. 2). These types of interventions focus on creating changes in knowledge and attitude about suicide in the population, sometimes targeting specific professions such as health care workers and school teachers (who are more likely to be in contact with suicidal people), and sometimes targeting every member of a population (as in anti-stigma campaigns).

A small section of the research also concerns interventions in specific areas such as building management, transportation structures, gun control policy, and media reporting censorship (Mishara, 2012; Beautrais, 2007; White & Stoneman, 2012). For example, Briann Mishara explores the prevalence of suicide by jumping from both bridges and buildings to suggest that city planning policies concerning both the height of tall buildings and bridges and the access to rooftops or edges do have some relevance to suicide prevention efforts (2012). In a similar vein, Annette Beautrais reviews literature of suicide by train injuries to illuminate how planning concerns such as suicide rails, location of train stations, and barriers to tracks play an important role in preventing suicide (2007). Lastly, the issue of media reporting has emerged in the literature as relevant to the suicide rate, as open and honest reporting of suicides has been shown to increase the suicide attempt rate in the population (Beautrais, 2007; Leenaars & Wenckstern, 1999). These interventions target the policy arena, casting a wide net on the relevant spaces and places in which suicide could emerge as a problem.

Interestingly, while there is much social and governmental support for a range of mental health strategies, including suicide prevention initiatives (White & Pike, 2013), there is less consensus in the literature about the effectiveness of any single suicide prevention effort. This is especially surprising given the strong push for evidence-based suicide prevention research both in academia and practice (White, Marsh, Kral & Morris, 2016; Bates, 2011). Still, while some

research suggests that current interventions do make an impact, other studies propose that the impact can be minimal or even negative (Leenaars & Lester, 2004; Barber, Blackman, Talbot & Saebel, 2003; Beautrais, 2007; Mishara, 2012; Hughes, Hayward & Finlay, 2009; Agar-Jacomb & Read, 2009; Webb, 2016).

In speaking to the positive effect of suicide prevention services, Coveney, Pollock, Armstrong, and Moore (2012) researched the effectiveness of the Good Samaritan Helpline (a UK Crisis Call Center) to determine its ability to improve client distress in the immediate and short term duration. The authors found the helpline had a significantly positive impact on client distress, with study participants reporting that they felt more hopeful, less suicidal, listened to, understood, and supported after the call (Coveney, Pollock, Armstrong, and Moore, 2012). Additionally, many participants felt they had benefited from the advice given to them from the helpline volunteers and the chance to work out appropriate solutions to their struggles (Coveney, Pollock, Armstrong, and Moore, 2012). Other research supporting the positive impact of current suicide prevention strategies includes studies showing that some clients appreciated their experience of being hospitalized for their distress and felt it contributed to their improvement (Hughes, Hayward & Finlay, 2009).

However, while some studies have displayed the effectiveness of these kinds of interventions, most research in this area presents either a neutral or negative correlation between current suicide prevention services and reducing suicidal distress in individuals. For example, while Mishara (2012) and Beautrais (2007) support policy changes in city planning and building management as a suicide prevention strategy, they suggest that overall these sorts of interventions have little impact on the suicide rate. Moreover, given that these prevention methods function at a planning level, it is impossible to tell if they prevent suicide or merely prevent specific kinds of

suicide by diverting people from one method to the next (Beautrais, 2007). Additionally, the popular suicide prevention method of telephone helpline support has been scrutinized in research, with some studies indicating that there is little to no impact of these kinds of interventions on reducing the suicide rate (Leenaars & Lester, 2004; Barber, Blackman, Talbot & Saebel, 2003).

With a more direct critique of current methods, Sarah Lewis and Albert Roberts (2001) call for more rigorous crisis assessment interventions. Implying that assessing suicidality is one of the most effective ways of preventing its completion, they call for a more standardized, systematic, and numerically accurate approach to determine risk in clients. Moreover, according to Lewis and Roberts, this more routine and evidence-based practice will improve the effectiveness of current suicide prevention work. Other authors also heavily criticize current methods in suicide prevention. For example, Rosalie Hughes, Mark Hayward & W. Finlay (2009) discuss the negative effects of current treatment in inpatient unit hospitalization. Through conducting a qualitative research study on people who had been hospitalized for various mental health problems in the UK, they conclude that inpatient care has the potential to disrupt patient's sense of self and competence, leading to poor recovery and stress on their relationships with caregivers (Hughes, Hayward & Finlay, 2009). Expanding on this research, other studies have demonstrated that the negative consequences of inpatient treatment include "being traumatised, stigmatised, dislocated from the community, and increased likelihood of future hospitalization and dependence," as well as the subjective distress of feeling "bored, isolated, unsafe, and powerless" (Agar-Jacomb & Read, 2009, p.99). Although these studies did not pertain specifically to clients with suicidal distress, they do speak to the effectiveness of a method of mental health intervention which is used for suicidal ideation as well as similar emotional disturbances.

While the above critiques focus on the effectiveness of specific methods of suicide prevention, recent research and theory in the field of critical suicidology has shaken the very assumptions that current suicide prevention initiatives rest on. For example, theorists and researchers have challenged the unquestioned notions that suicide is a mental illness, that suicide is caused by depression, that inpatient and involuntary treatment reduce suicidal distress, and that suicide assessments can accurately determine someone's level of risk (Marsh, 2016; Webb, 2016; Wexler & Gone, 2016; Hjelmeland, Dieserund, Dyregrov, Knizek & Leenaars, 2012). These critiques assert that current suicide prevention efforts are not effective (or not effective as they could be) because they rely on false ideas about suicide and its causes. For example, in addressing the controversial notion that the most useful research in suicidology is positivist, 'objective' and quantitative, Heidi Hjelmeland (2016) argues that these kinds of studies can instead encourage a furthering of reductionist, decontextualized, and objectifying suicide prevention methods which will only negatively impact those who seek help. Likewise, in their study of suicide prevention interventions in Canadian Indigenous contexts, Lisa Wexler and Joseph Gone (2016) contend that current individualising, pathologizing, and isolating aspects of suicide prevention work do more harm than good in Indigenous communities that continue to struggle with the effects of a colonial history of violence and genocide. Instead, they argue for a re-imagining of suicide and its 'solutions' that are culturally-appropriate and guided by Indigenous communities themselves.

Thus, the research regarding the effectiveness of suicide prevention interventions ranges from belief in a positive correlation between prevention methods and lowering suicidal distress to a belief in the inherent misguidedness of current suicide prevention ideology and methodology.

## **Locus of Intervention**

A second dispute in the literature is what the appropriate locus of intervention is to relieve suicidal distress and suicide completion (Canadian Association of Mental Health, 2011, Lewis and Robarts, 2001; Mishara, 2012; Beautrais, 2007; World Health Organization, 2014; Leenaars & Wenckstern, 1999; Hjelmeland, 2016; Morris, 2016; Webb, 2016; Willis, Coombs, Cockerham, & Frison 2002; Tousignant, Vitenti & Morin, 2013; Wexler & Gone, 2016) . The array of opinions on this issue range from the individual, to the structural, to the discursive. Importantly, these opinions tend to map onto political values, such that mainstream suicidology research tends to take for granted an individual and pathology focus, and more critical and social-justice oriented research tends to support a more structural and contextual locus of intervention. For example, the Canadian Association of Mental Health adopts a heavily medical, pathological, and individual sense of suicide prevention, which fits well with the organization's mission to use individually-based mental health services to prevent suicide and relieve distress (Canadian Association of Mental Health, 2011). Similarly, as mentioned earlier, Lewis and Roberts (2001) see suicide assessment as the most important tool in suicide prevention because their research posits suicidality as a pathology of the individual. In this way, these researchers promote certain kinds of individual interventions as most effective and sensible based on their idea of where suicidal ideation originates from (White & Stoneman, 2012).

Conversely, other researchers have focused on other 'causes' of suicidal distress, such as structural and societal causes. Also mentioned previously, some research has noted how the physical structures of an environment can invite or hinder suicide attempts (Mishara, 2012; Beautrais, 2007), or acknowledge that other people (such as 'gatekeepers') make a substantial impact on the lives of those who are suicidal (World Health Organization, 2014; Leenaars &

Wenckstern, 1999). These approaches appreciate that the social environment does have a relevant place in suicide prevention policy.

Taking this idea further, some authors explore the ways that society itself creates the conditions which sustain individual's feelings of suicidal distress. Relevant in the literature is research and theory that takes as its starting point that "suicide is characterised by multiplicity, instability, social context, complexity, and historical contingency" (White, Marsh, Kral & Morris, 2016, p. 4). Researchers in this area of work have argued for the recognition of a cultural context which structures how people comprehend their distress. In other words, pain and distress are given meaning through a person's interaction with their local community and society more generally (Hjelmeland, 2016; Morris, 2016). This mentality has encouraged theorizing on alternative ways of responding to suicidal distress that encourage a community or society shift, instead of merely a change in the lives or thinking of individual suicidal people. For example, David Webb (2016) theorizes the suicide prevention response of "healthy communities" in which whole communities realize the importance of suicidal (as well as mad) feelings and have the infrastructure to give space to individuals who are working through 'crises of the self'. Some alternative mental health care initiatives have tried to embody this sentiment on a smaller-scale in Germany (Soteria) and New York (Project Release) with positive results (Starkman, 2013; Menzies, LeFrancios & Reaume, 2013).

A more society-oriented and culturally-aware perspective on suicide prevention interventions has led to the development of important research and theory which considers the place of history in relation to people's experiences of suicidal distress (Willis, Coombs, Cockerham, & Frison 2002; Tousignant, Vitenti & Morin, 2013; Wexler & Gone, 2016). Research on the higher rates of youth and adult suicides in the Canadian Indigenous population has shown



that the historic violent, colonial, and genocidal policies and actions against Indigenous communities in Canada has been a leading factor in these higher numbers (Tousignant, Vitenti & Morin, 2013; Wexler & Gone, 2016). This research identifies how the long history of Canada's targeting of Indigenous spiritualities, forms of governance, and economic livelihoods has created the social conditions of social alienation, poverty, crime, and mental health struggles which all contribute to the suicide rate (Tousignant, Vitenti & Morin, 2013). Because of these structural inequalities, "suicide in Indigenous communities is often conceived of as the terminal outcome of historic oppression, current injustice, and ongoing social suffering" (Wexler & Gone, 2016, p. 59). Moreover, as the previous quote exemplifies, literature on this topic illustrates how historic factors are not only relevant as context to understand current situations; they also shape social justice and policies concerns. For example, Wexler and Gone caution mental health professionals against taking suicidal youth out of their community and placing them in inpatient facilities, since this action can "echo the coercive removal of an entire generation of Indigenous children" and is an "extension of cultural subjugation and colonial intrusion" (2016, p. 64).

This focus on social justice as the best arena to prevent suicide has also been discussed in relation to other marginalized peoples (Bauer, Pyne, Francino & Hammond, 2013). Research has demonstrated how microaggressions and oppressive violence can cause suicidal ideation in marginalized groups, such as African Americans and LGBT people (Walker, Salami, Carter & Flowers, 2014; Bauer, Pyne, Francino & Hammond, 2013). Additionally, this research explores how historical factors shape the opportunities and access marginalized groups have in employment, education, and mental health services, narrowing people's options and faith in their future (Willis, Coombs, Cockerham & Frison, 2002; Bauer, Pyne, Francino & Hammond, 2013). Because of these realities, Bauer, Pyne, Francino & Hammond, focusing on suicidality in trans

Ontarians, encourage social workers to recognize where trans erasure and barriers to access exist in social service spaces, making social services more accessible for trans people to turn in times of distress (2013).

Another locus of intervention that appears in the literature is the level of discourse. In this framework, suicide is understood as a fluid, socially constructed idea with historically shifting boundaries, making it amendable to change. For example, throughout history, suicide has moved from being conceived of as a sin, to being considered a crime, to today's conception of suicide as a mental illness (White & Stoneman, 2012; Marsh, 2016). Current dominant constructions of suicide regard it as a burdensome, depressive experience, a consuming and ubiquitous state and a primarily medical issue, with the suicidal subject being viewed as passive, lacking agency and requiring assistance from mental health professionals (Morris, 2016). Most importantly in this research is its potential to create change by shifting how suicide is understood, and thus, responded to. This research explores what alternative discourses of suicide prevention could mean for policy-work, such as policy initiatives that locates the responsibility of change not in suicidal people, but in structural systems that create oppressive conditions (White & Stoneman, 2012). Additionally, at a discursive locus of intervention, there is room for individuals to adopt alternative definitions of struggling with suicide, which do not adhere to stigmatizing and medicalizing dominant models (Morris, 2016).

Thus, the literature shows that research on suicide prevention has a vast array of opinions about the appropriate locus of intervention, ranging from individual, to structural, to societal, to discursive.

## Place of Lived Experience in Research and Practice

The last significant theme in the literature regards the place of lived experience in shaping both theory and practice in suicide prevention research. A turn towards supporting people with lived experience as theorists, consultants, and evaluators of programs and initiatives emerged with the introduction of critical suicidology and Mad Studies in the 2000s. For example, while in mainstream literature “the actual suicidal person [is] remarkably absent from...expert knowledge” (Webb, 2016, p. 87), critical suicidology realises “when we silence...subjective material... we inevitably make mistakes in terms of how we understand people and how we respond to them” (Shaw, 2016, p. 79-80). Research in this area has asserted that the voices of suicidal people, including those with histories of suicidal feelings, must be at the center of any analysis, for only then can researchers comprehend the meaning that is ascribed to both feeling suicidal and the act itself (Webb, 2016; Hjelmeland, 2016; Shaw, 2016). In fact, some authors argue that research based in lived experience “carries an inherently enhanced credibility *because* of direct experience” (LeFrancios, 2016, p. v, emphasis in original) as well as note that research questions regarding suicidality “cannot be answered *reliably* by anyone other than the [suicidal] person” (Hjelmeland, 2016, p. 38, emphasis in original). In this way, placing people with lived experience at the center of the research has contributed immensely to enhancing both theory and practice (Sweeny, 2016; Russo & Sweeny, 2016; Shaw, 2016; Hughes, Hayward & Finlay, 2009; Agar-Jacomb & Read, 2009).

This shift to prioritizing the voices of those with lived experience illuminates the social justice orientation of the researchers in the critical suicidology field. Noting the historic silencing and disregard of people who experience suicidal distress, these researchers aim to transform systems of care to better meet the needs of the very people they are meant for (White, Marsh, Kral,

& Morris, 2016; Agar-Jacomb & Read, 2012). One of the most significant findings of research based in this model has been the link between supportive and healthy relationships and people's capacity to heal and grow from their distress. For example, Clare Shaw, in speaking about her own experience of being psychiatrized for self-harm, notes that the 'best treatment' for her was simply the supportive nurse aids who took the time to listen to her and make her feel cared for (2016). More generally, qualitative data in this area has documented the relevance of relationships in both alleviating suicidal distress (Hughes, Hayward & Finlay, 2009; Shaw, 2016; Wexler & Gone, 2016) but also contributing to suicidal distress (Barber, Blackman, Talbot & Saebel, 2004; Wexler & Gone, 2016) as well as creating hope for recovery (Marsh, 2016). These studies illuminate the necessity of centering the experiences and voices of people with histories of suicidal distress, who have the most insight into what effective and compassionate suicide prevention responses can look like.

Thus, research in the literature has illuminated the benefit to both research and practice of centering the voices of those with lived experience.

These three research areas of effectiveness of current interventions, locus of intervention, and the relevance of lived experience provide an outline of current ideas, methods, and practices in suicidology research today. Within this background, participant voices rest in a context in which the causes and responses to suicidal distress are highly contested and moulded by competing interests.

## **Theoretical Overview and Methodology**

### **Overview of Theory**

Historically, mental health research has been dominated by positivist research paradigms, which see suicidal distress as an individual pathology that can be categorized, controlled, and prevented through rigorous medical studies (Hjelmeland, 2016). This positivist focus has led to a pre-occupation with research questions regarding risk factors and ‘causes’ of suicidality such as poor brain chemistry (Hjelmeland, 2016; Marsh, 2016). Moreover, these sorts of research questions have created suicide prevention policy which focus primarily on social responses such as suicide awareness education, gate-keeper training, screening programs, skills development, social support enhancement, means restriction, and media censorship of suicide attempts (White & Stoneman, 2012). While these research questions and societal responses have a significant place in social work research which aims to alleviate the pain of people in distress, I choose instead to adopt a critical framework which centers on examining the place of social structures in contributing to suicidal distress as well as changing institutional responses to better meet people’s needs.

The specific critical social science fields I drew on for this thesis project are two different but very related areas of inquiry. Firstly, I used critical suicidology, which aims to unearth new ways of doing research (such as interpretive, existential, and lived experiential) to expand on a concept that has often been too narrowly studied as a quantifiable and medical concern (White, Marsh, Kral & Morris, 2016). Additionally, I drew upon Mad studies, which is a “project of inquiry, knowledge-production, and political action devoted to the critique and transcendence of psy-centered ways of thinking, behaving, relating, and being” (Menzies, LeFrançois, & Reaume, 2013, p. 13). In this way, I used a critical social science framework (CSS) which has potential to

offer different questions about the experience of suicidal distress and uncover more complex, nuanced, and humane data, as well as being cognizant of the political imperative to change systems which dehumanize and disempower users/survivors of suicide prevention services (Brown & Strega, 2005).

### **Basic Assumptions of Critical Social Science**

**Social Construction of Reality.** Critical social science (as well as critical suicidology and Mad studies) understands the world as constructed by historical, economic, political, and cultural factors. Thus, reality is not real by virtue of being natural and given, but because of historical discourses and structures which give meaning to our lives and shape the opportunities we have access to (Brown & Strega, 2005; Neuman, 1997). For example, both critical suicidology and Mad studies recognizes the time-specific context we live in. Ian Marsh, for instance, shows how the idea of suicide as an individual and pathological illness only emerged during the late 1700s, and only because of the burgeoning field of medical science and its domination over “the mad” (2016). Thus, the labelling of certain thoughts, feelings, and behaviours as a medical defect is only made possible by that historical and cultural increasing influence of the psychiatric discipline. The reality of people’s oppression, however, is not a contested reality in CSS (Brown & Strega, 2005; Neuman, 1997). That mad people and those experiencing suicidal distress are materially (and negatively) impacted by current ideas about and social responses to suicide is a building block of critical suicidology and Mad studies.

**Knowledge as Political.** Another basic assumption in CSS is that knowledge is not merely neutral facts, but is political (Kincheloe & McLaren, 2002; Brown & Strega, 2005; Neuman, 1997). In other words, what we believe is true shapes how we understand and interact with the world, which includes what we think is a problem, and what solutions to these problems might be.

Knowing that the results of any research have these political implications, it is easy to see how CSS then demands that any inquiry into social problems must aim to critique and change current oppressive conditions. Critical suicidology and Mad studies, following in this tradition, acknowledge that “[d]oing social theory always means recognizing that things could be otherwise; that – to borrow a phrase... “another world is possible” (Connell, 2011, p. 6).

**Privileging Lived Experience.** Lastly, critical suicidology and Mad studies both posit lived experience as crucial to the research process, with the assumption being that only a field of inquiry that heavily privileges lived experience can keep focused on its emancipatory potential (Beresford, 2016). Brenda LeFrancios, for example, argues that research, theorizing, and knowledge-production undertaken by mad folk “carries an inherently enhanced credibility *because* of direct experience” (2016, p. v). LeFrancios, Beresford, and Russo similarly assert that research can only transform practice when it involves practitioners “learn[ing] from those who have been psychiatrized” (2016, p. 3). Speaking about the potential for ‘insider knowledge’ to shift current suicide prevention practices, Jonathan Morris questions “what kinds of conversations could take place if young [suicidal] people were positioned as “knowledge providers” instead of “knowledge recipients” (2016, p. 89)?

## **Methodology**

Methodologically, with the aim of centering the critical and change-oriented aspects of the research question while also privileging the lived experience of the participants, I drew from the fields of critical social science, critical suicidology, and Mad studies to apply a ‘methodological pragmatism’ common in survivor research that “selects the method most appropriate for exploring a particular question (Morgan, 2007); but crucially, this occurs within a broader transformative emancipatory paradigm (Mertens, 2003) that foregrounds first person knowledges,” (Sweeney,

2016, p. 50). In this way, I chose to conduct semi-structured interviews guided through an interview guide with people with experiences of suicidal distress. Through these interviews, I gathered data about participants' subjective understanding of suicidal distress, their experience 'reaching out' to others, and their suggestions for change in the mental health system. The data analysis was also shaped by the imperative to center both social change and lived experience, leading me to theme the transcripts in an attempt to highlight the context of participants' experience of suicidal distress and their ideas about systems change.

**Research Question.** Before beginning the methodological process, I selected the research questions. The research questions I chose to explore are "what are people looking/hoping for when they 'reach out for help'?" and "what kinds of responses do people want?". By asking these question, I was able to examine the mental health system in light of what participants value in the care they receive, allowing me to both critique current institutionalized ways of responding to distress and imagine alternatives which better meet people's needs. These research outcomes align my study with a critical social science, critical suicidology, and Mad studies framework (Brown & Strega, 2005; Neuman, 1997; White, Marsh, Kral & Morris, 2016; Beresford, 2016).

**Interview Guide.** Next, I constructed the interview guide. This guide would later serve to shape the interview proceedings and the data analysis. As seen in Appendix C, the interview guide outlined eight questions, four of which centred around the theme of 'experience' and three of which centered around the theme of 'alternatives'. The final question simply asked "Did I miss anything? Is there anything else you think I should know?", to give participants the opportunity to introduce or restate interview content they felt was important.

The first half of the interview guide, called 'experience', posed questions about the kinds of feelings, thoughts, and needs participants had at the time of their suicidal distress. This section



also queried participants' negative and positive experience of 'reaching out' to friends, family, and mental health professionals. Lastly, this section inquired about how participants understood their suicidal distress, including if they felt others understood their distress in a similar or different way. The second half of the interview guide, called 'alternatives', sought to explore what changes participants would make to their past experiences 'reaching out' for help, as well as what changes they would make to the mental health system, and suicide prevention efforts, more generally if they could. Additionally, this section gave participants a chance to share what their 'ideal' mental health system would look like to them. Within these questions, participants were also given room to express their positive experiences with the mental health systems and what aspects of current suicidal prevention initiatives they would specifically not change. (See Appendix C for more details).

Primarily, this interview guide was crafted to address the research questions (see above). My intention for the first half of the interview guide was to explore the context of participants' experience, primarily to answer my first research question ("what are people looking/hoping for when they reach out for help?") but also to uncover data to better support potential systems change. More obviously, the second half of the interview openly queried participants about their preferred responses, openly addressing my second research question "what kinds of responses do people want?"

While my primary motive when constructing the interview guide was to select questions which would elicit the data I needed to answer the research questions, I was also guided by the desire to be transparent about the goals of the research to the participants. Being transparent and accountable to research participants is a core principle in survivor research (Faulkner, 2004), and I sought to practice this tenet by making the interview guide clearly organized around the themes

of experience and alternatives to notify participants of the boundaries of the research interest and the political motives. Another concern I had while constructing the interview guide was to prevent causing distress to the participants as they recounted their experiences of suicidality. Therefore, I sought to pose only those questions necessary to gather the relevant data (to avoid disrespectful prying) and to provide participants the opportunity to discuss change after talking about their experience. In this way, I hoped to allow participants to leave the interview feeling more hopeful than troubled.

**Ethical Approval.** The next step of my methodological process was to receive ethical approval for the use of human participants in research. As part of this step, I secured McMaster Student Wellness Center as a debriefing service. This way, if participants felt unsettled either during the interview or in the days after, they could speak to a counsellor. I felt this was a necessary precaution to take because of the sensitivity of the topic and the possibility of participants being triggered.

**Recruitment.** After receiving ethical approval from the McMaster University Research Ethics Board on May 3 2017, I began recruiting by email through McMaster-based listservs which had the potential to reach participants with experiences with suicidal distress (See appendix A). Additionally, I posted flyers on McMaster University campus boards (see Appendix B). To be qualified for the study, participants had to have had experiences with suicidal distress and be able to meet for an hour-long interview. However, because the debriefing service used for the study was Student Wellness Center at McMaster University, participants also had to be McMaster students, as Student Wellness Center's mandate prevented them from offering their services to non-students. Therefore, the sample was limited by this logistical issue.

Recruitment lasted about 5 weeks. I capped the number of interviews to 4 participants because of the short time frame I had for the study; I felt that it would take too much time to interview, transcribe, and analyse more than four interviews. While emailing participants to set up interview times, I provided them with the Letter of Information and Consent as well as all the interview questions. This was done pragmatically to encourage participants to consider their answers beforehand. However, this action also contributed to furthering transparency as it provided participants with the purpose of the study and their part in it, as well as the boundaries of the discussion I was hoping to have. Importantly, this allowed participants to determine if they were ready and able to take part in this conversation and decline the interview if not.

**Interviews.** Between May 30th and June 22nd 2017, the four interviews took place. Interviews were conducted based on the interview guide, although participants were assured they had the right to skip any question they did not wish to answer in order to respect their dignity and choice as both participants and consumer/survivors (Faulkner, 2004). After reading participants the letter of information and consent and gaining their consent, I again informed participants of the purpose of the research and their part in it as well as explained how the interview would be divided into two sections, ‘experience’ and ‘alternatives’ (see appendix C). Again, my intention was to outline the questions beforehand to be transparent with participants about what I was hoping to talk about during the interview. This was done for two reasons. Firstly, I sought to be clear about the boundaries of my research and political interests with my participants as a way to practice accountability. Secondly, this technique was used to prepare participants for the questions I would ask in order to minimize unnecessary distress. After outlining the questions, I asked each question consecutively, although I would skip questions if they had already been addressed by participants earlier in the interview. As participants responded, I would also take notes, however I found myself

taking fewer notes as it was more appropriate to listen attentively. Interviews ranged from 38-81 minutes and took place at McMaster University, although participants had been given the choice to meet at an outside location if they wished. The interviews were recorded on my cell phone.

While conducting the interviews, I also had the additional task of addressing participants' distress if they were triggered during our discussion. Fortunately, none of the participants showed any signs of distress and all said they were okay when I asked how they were. I believe sharing the questions in advance as well as attentive listening was a useful tactic in mitigating the difficulties in talking about this sensitive issue.

After 3 interviews were completed, I transcribed them, then did the fourth interview and transcribed it as well.

**Data Analysis.** After the interviews were all transcribed, I began analysing the data. My data analysis technique was to 'theme' the transcripts to reveal specific information that I was looking for to address the research question. Moreover, the specific themes I was looking for were already captured in the interview guide. The first half of the interview questions had given me data about the context of people's experiences of suicidal distress as well as their experiences 'reaching out' for help. The second half had given me data about people's preferred systems of support and responses from social work. In this way, there were a certain number of themes that I aimed to cover, such as affective and cognitive experience (question 1), preferred responses (question 4), suggestions for change (questions 6 and 7) and so on. In fact, each question had one or more predetermined themes I wanted to address within the question. In this way, I aimed to use the interview guide to sort the findings while continuing to center the research questions.

I began with interview one and combed through the data to find these themes, and then did the same for interview two, three, and four consecutively. Very quickly it became apparent that

some questions were less interesting for the participants than others. For example, the question “In your opinion, how did the people you reached out to understand your distress?” did not garner much interest from participants or substantial data. Therefore, the findings do not reflect this theme.

When all the data had been themed, I then compared the results of the theming from interview to interview. This led me to notice that there were many common feelings, sentiments, experiences, ideas, and understandings among the participants within the theming fields. It was these commonalities which I took to be the final findings. After this, I organized the findings into three sections: ‘the nature and creation of suicidal distress’, ‘the process and experience of ‘reaching out’’, and ‘toward a better model’. These three sections were organized primarily around the findings, but also based off the interview guide, and again, the research questions. For example, the section on ‘nature and creation’ of suicidal distress involved many of the responses to question 1, 2, and 3 of the interview guide. The section on ‘process and experience of suicidal distress’ was heavily supported by participant answers to questions 3 and 4. Lastly, the final section ‘toward a better model’ was crafted through the participant responses to the final questions 5, 6, and 7.

## Findings

After speaking with the four participants invited to share their experiences, thoughts, feelings, and ideas for change about suicidal distress, I had a wealth of data covering a broad array of topics. While my interview guide and research questions narrowed the range of responses to focus on personal experience and understanding of suicidal distress, experiences of ‘reaching out for help’, and ideas about change to suicide prevention systems, participants used this space to speak to a number of different issues they felt were related to the questions, even pushing the boundaries of questions to discuss issues which my questions did not speak to. Still, the range of responses were captured in three overarching themes: the nature and creation of suicidal distress, the process and experience of disclosing, and thinking about a better model of practice.

### **The Nature and Creation of Suicidal Distress**

**Suicidal Distress as Ongoing.** Crucially, all participants spoke about suicidal distress as both an ongoing experience as well as a response to life situations and social realities. Participants stated that suicidal distress is experienced “day in and day out” over a long period of time, with some participants stating the time frame of 10 years or more:

“its like a repeated, a thing that I struggle with day in and day out...it’s like a continued period that I will feel it”

“its not like I’m never not feeling suicidal and its not like I am feeling particularly suicidal. Its not a discreet thing, its something that kind of comes and goes in intensity.”

“I can't pinpoint it to one time when it kind of spans over... it gradually kind of builds up I guess. And like a lot of different feelings plays a part into that”

“I’ve been dealing with it for a long time. It’s been at least 10 years”

Instead of being a discreet feeling or specific time, suicidal distress is experienced as a continued period, gradually building up. In this way, suicidal distress is experienced as always there, a deep-seated part of life and who people are:

“How are we supposed to take the suicidal distress or ideation out of you, when it’s part of who I am and it’s part of what the structures create”

“ [It] exists as a part of my life”

Additionally, all participants understood their suicidal distress as a response to either life situations or social realities, noting that the feelings of suicidal distress differ with changes in life, often citing new stresses or the compiling and continuing of older issues as factors that create new or different suicidal feelings. Whether is be bullying, compiling stress, years of depression, or repeated social barriers, all participants expressed a notion that their experience of suicidal distress was more complex than one time or one feeling:

“It's more like the repeated barriers that I have to face whether it be with my physical disability...it's just that and like trying to navigate all the systems”

“they're [suicidal feelings] very based on our response...to... what was happening in my life at that time, ... whether it was extensive bullying...or whether coming into identities...whereas later...it’s feelings of isolation”

“its more of the depression part where you just don't feel like doing anything and just sad where you don't feel anything, and you just don't care. The stuff that leads up to the thoughts.”

“While dealing with stress in the home-life...And then be in an abusive relationship with a partner. So everything was just kind of like compiling onto each other.”

**Affective Experience of Suicidal Distress.** Although there was no agreed upon set of feelings that participants understood as ‘suicidal distress’, there were some similarities in the affective experience. Three of the four participants expressed a sense of being trapped, restricted, consumed, or overwhelmed by suicidal distress to the point where they did not feel they could cope with or respond to the situation in the moment:

“My life feels like a perpetual Chinese finger trap”

“I was so consumed with the feelings that were associated with what was going on and I couldn't let go of that and it was like so invasive”

“I wanna die but I end up not being able to go through with it”

Additionally, those same three out of four participants discussed feelings of sadness described as: “the lowest you can imagine” as well as “negativity [that] take[s] over,” making “everything negative”. These descriptions illuminate feelings of sadness which manifest intensely and completely. Other affective experiences within the notion of suicidal distress that participants referred to are confusion, fear, anger, and a sense of not belonging:

“confused about like "why am I feeling like this?"”

“it was so scary because it was like I wasn't even myself”

“If I'm angry I'll just go out and say "I'm going to finally do it, like I'll kill myself””

“I feel like a misfit in the world”

Notably, one participant did not address their affective experience of suicidal distress.

**Awareness of Dominant Discourses Regarding Suicidal Distress.** Importantly, two participants spoke of the way suicidal distress is understood in professional social work and medical discourses, showing a strong awareness of how these models misunderstand or simplify their own experience. (Two participants did not speak to this subtheme). For example, these



participants spoke of how suicidal distress in mainstream culture is understood as ontologically separate from the individual, resulting in mental health and social workers aiming to “take the suicidal distress or ideation out of you”:

“They say... ‘there’s suicidal distress or ideation and then there’s you’”

“Its framed as the only way to exist in recovery is an erasure of mad identity”

In this way, these participants understood mainstream social service culture as positing suicidal distress as fundamentally distinct from the human experience, outside of the possibilities of ‘normal’ subjectivity. Another professional notion which these participants problematized was the idea of suicidal distress as an isolated event, distinct in time and affect:

“I think [social work] views ...distress as isolated events”

“Like an internal bio-medical switch that's just been flicked and [service providers] need to flick it back the other way”

Moreover, these participants noted how these conceptions of suicidal distress as separate and discreet encourage certain ways of thinking about ‘recovery’, such as a focus on symptom erasure and management, immediate coping strategies like deep breathing and calling a hotline, or stabilizing medication, solutions that these participants did not feel made sense with their understanding of their own distress:

“if I look up [coping with suicidal distress] on the internet, its like "go to meditation", "take a deep breath", "call a hotline"...But like, this is constant, every day, every minute”

“we're opting into a very biomedical recovery model where its like, "the symptoms have gone away" or "I've learned to manage them" or like "Look at all these coping strategies I learned' And its very much framed as the only way to exist in recovery is an erasure of mad identity.”

Participants raised these notions to define themselves against these models, expressing how their own interpretation of their experiences complicates and challenges these ways of thinking about suicidal distress:

“[In school] I’m always hearing the rhetoric of ‘view it this way’ and ‘due to the code of ethics’ And its like, no, just let me have my experience”

Additionally, participants also addressed the ways these dominant, medical models of suicidal distress impacted the capacity of workers to respond appropriately, instead encouraging check-list oriented, quantifiable results:

“We’re so pushing on wanting to be super like “yeah, we’re gonna talk about it and we’re gonna like help people with it” but a way of doing that is just putting it into the DSM or something like that. And making it something that a doctor can check off a list to see if you have...”

“Like looking at this like a medical thing with symptoms, like we classify it and stuff like that because when you look at in this model you’re going ‘Oh you either meet them, but do you meet them enough?’”

“I get in trouble for [talking with clients] because it ‘takes too long’”

“Both experiences are very, very valid but neither of them is being taken into account in this quantifiable, quantity-based system”

“Like humans, stop trying to look to the code of ethics. Stop trying to cover your butts. Stop trying to look to evidence based. Stop trying to throw this out like a temporary fix.”

**Structural Understanding of Suicidal Distress.** Additionally, in line with understanding suicidal distress as ongoing and integrated into life, all participants attributed at least part of their suicidal feelings to the reality of slow-changing (or unchanging) oppressive or

disempowering social forces. Some specific forces mentioned during the interviews were ableism and its related social barriers, lateral violence as a result of colonial oppression, and internalized self-hatred in response to societal homophobia/heterosexism:

“It's more like the repeated barriers that I have to face whether it be with my physical disability...it's just that and like trying to navigate all the systems”

“I was actually not [functioning] cuz of all the stress, lateral violence that's going on and still going on in [my] Indigenous community”

“I think like being in a queer body there's a lot of self-hatred that's just like programmed in there”

Participants understood these forces in their own lives, but also addressed the relevance of oppression more generally. All four participants specifically expressed a structural or social construction viewpoint, in which suicidal distress was linked to social forces, such as awful conditions or trauma, that were not only beyond individual tragedy but constructed socially:

“the way that I view suicide is ‘a world that's not working’”

“You know we never call it like "because life because life is shitty””

“I view suicide from a lens of a response to things going on... a response to what are either awful conditions or like an interpersonal trauma”

“these huge larger forces come into play and actually trickle down and influence individual experiences even with like suicidal ideation and suicidal distress”

In particular, one participant located a cause of suicidal distress within the very process of becoming marginalized:

“feeling suicidal, feeling like I want to kill myself- these things don't necessarily go away because I think they're positioned in how we view marginalization. They're positioned in

how trauma works and things like that. And they're kind of held in there, so I don't think I can necessarily operate in any of these identities without feeling these things [suicidal distress]”

Similar to the structural lens expressed by some participants was a social construction lens, discussed by two participants:

“it’s been like a movement combined effort between communities and religions to like villainize the thought of suicide”

“Its like the way that we create things in society that will make it happen”

In this way, all participants located the ‘cause’ of suicidal distress within larger social forces in some capacity, for one participant so much so that they suggested a way to alleviate the social problem of suicide is to “change culture”: “I think the culture change thing is a big thing”. Importantly, however, one participant mentioned the importance of recognizing not only those external and structural ‘causes’ but also the subjective, internal, and personal nature of suicidal distress:

“its just leaving out that struggle she felt internally of the feelings and everything that she felt personally”

**Media as an Influence in Understanding Suicidal Distress.** Along with addressing the socially constructed and structural nature of suicidal distress, two participants also noted how media, as a purveyor of social discourse, might influence how suicidal distress is understood and experienced. These participants spoke to how commercials and television shows advance certain ways of understanding suicidal distress, such as when medication commercials promote medical-model frameworks or the currently popular Netflix series *13 Reasons Why* (2017) - a story about

a teenage boy uncovering why his late crush killed herself - encourages viewing suicide through the lens of revenge:

“even commercials for like mental illnesses and stuff, a person is depressed and is being followed around by this dark cloud and then they take meds and then there’s the sun as if its as simple as just like darkness and lightness”

“13 reasons why I think is framing suicide in a way that, it’s like the main character was using suicide as a way to get back at someone”

One participant furthered this analysis by discussing how in their case, media encouraged certain ways of performing suicidal distress as their first time “reaching out” was influenced by ‘degrassi and glee-esk’ narratives (see *Degrassi: The Next Generation* (2002) and *Glee* (2009), television shows which follow teenagers through the drama of high-school life):

“so then it was like this whole like, “I might not be here tomorrow” which I think was reflective of like, media portrayals of high school grade 7 8 like very degrassi, glee-esk”

Both participants also suggested that media representations and their inherent discourses do impact the way they interpreted or did not interpret their own struggles:

“Like what the media was kind of talking about then, like that is the representation of like what someone who is feeling suicidal should kind of perform”

“Making these discourses about suicide available to everyone would help. Cuz ...if I were to read some of the [more discursively diverse] articles that I’m writing now when I was going through everything, I think it would have helped me.”

Notably, two participants did not address media during the interviews.

**Regulation as Part of the Experience of Suicidal Distress.** Lastly, two participants discussed suicidal distress in a way which suggests a regulatory nature. These participants

expressed that they felt they ‘shouldn’t feel’ suicidal distress and in turn one participant had felt embarrassed, guilty, and confused about their suicidal feelings:

“a lot of times when I'm talking to people, especially professionals, I am like, I know I shouldn't feel this way because A, B, C, D”

“Like guilt and confusion, like I shouldn't be feeling this because you know, like we're taught that suicide isn't the proper answer”

“I didn't want to tell my friends for sure because I felt embarrassed”

Moreover, these feelings were not necessarily an inherent part of the experience of suicidal distress, but emerged because of the way others would react:

“You don't want people to look down on you so I didn't tell any of my friends”

These comments suggest that these participants felt a level of pressure against having suicidal distress which influenced how they interpreted their own experience.

Notably, two participants did not address a regulatory aspect of the experience of suicidal distress.

## **The Process and Experience of Disclosure**

**Reasons for Reaching and Not Reaching Out.** Addressing the topic of “reaching out”, participants suggested that both the choice to talk to others about their suicidal distress and the way in which they navigated and managed those conversations was a complex process. Two participants shared with me their reasoning for reaching out:

“I just thought that it would be in my best interest to say something for once”

“I have to...to disrupt the cycle of thoughts”

“[Its] a way for me to show myself that I'm worthy because I'm asking for these things”

Participants also spoke to their reasons for not reaching out, such as embarrassment about having suicidal distress, a belief that no one will understand what they were going through, or feeling unsafe to disclose:

“I didn't want to tell my friends for sure because I felt embarrassed”

“I was so stubborn and like "no one's gonna understand what I feel like, no one's gonna understand what I'm going through" so I didn't want to talk to anyone”

“I was afraid to actually reach out cuz when I was going to high-school...the counsellors would say things along the lines of "you can tell us anything". But if you ever say that you're a threat to yourself, they have to report to someone above them.”

Notably, one participant did not share their reasons for reaching or not reaching out.

**Nervousness About Reaching Out.** Importantly, a common reason why participants did not disclose, or were cautious to talk about their suicidal distress, was nervousness or even fear. For example, one participant spoke of the possibility of jeopardizing the necessary relationships they have with their caregivers and friends if they were to express how they felt:

“I have to be careful what I express because I have people that do a lot of...things for me”

Another participant addressed the possibility of a loss of power and even rights when one discloses suicidal distress, such as forced institutionalization, pressure to take medication or change current medication, or even the possibility of hindering school or workplace accommodations:

“in that kind of setting [social services] there's always a fear of like forced institutionalization, there's a fear of a medicine change, there's a fear of getting a new prescription, um, in the university setting they control academic accommodations- that's

not like a -I'm not a consumer in that sense, I'm very much someone who is not completely free in this interaction”

In this way, it was noted that disclosure entails the possibility of being “not completely free” or “in control” depending on the service provider’s response. Another participant remained cautious about their disclosure because of the fear of not knowing what would happen after they expressed their distress, stating:

“There was a great fear of actually vocalizing it, because I don’t know what would happen after that, who would they tell...would I get in trouble”

Now that I’ve entered this space, disclosed this experience to a medical professional, if they don’t feel convinced within their professional discretion that this is going to go away.... I’ve lost a lot of rights

**Language Used to Disclose.** Just as participants thought about the positive and negative consequences to disclosure, they were also cognizant of the ways they expressed themselves when they reached out. Most obviously, two participants spoke about the way they “navigated” their expression of their distress, working to be understood by others but also cautious of how those people might take up their words:

“I think I often find myself talking about these experiences using a discourse that’s been given to me say by service providers like a doctor...that becomes the language I use to describe the experience because it’s understandable by other people”

“But then I do have to navigate the way that I talk about things, like ideation and stress and God help you...if [it’s] a plan, like that’s it”

“We learn to utilize this language in ways that are protective”



Participants also spoke about using direct and forward language to best communicate their feelings when reaching out. This included talking about suicidal distress in an active way, such as saying ‘I want to kill myself’ instead of ‘I feel suicidal’, or focusing on the specific problems causing the distress:

“I prefer the language of "I want to kill myself" to "I'm feeling suicidal and feeling these things" ... "I want to kill myself" is much more generic, its a lot more understandable as like, "this is what's going on".

“I probably bring up what's bugging me”

**Navigating Systems.** Importantly, two participants used their knowledge of the mental health care system to navigate when and how they disclosed. These participants understood the system as procedural and focused on quantifying suicidal distress:

““It's hard when you're struggling because if you're not optimistic they take it the wrong way. And they're like “Oh, this person is in danger” and I'm not.”

“Cuz I know "Oh like if I say a 5th then they're gonna get really concerned so I have to like lie about this one or the intensity of that one” because it's kind of like "Oh if I get a score of blank out of 20 on this, then I know they now no longer have the choice and [I would go to] the hospital”

In this way, these participants chose to disclose in certain ways to navigate in and around the mental health system. As mentioned above, one participant expressed a pressure to be ‘optimistic’ while discussing their suicidal distress; otherwise the disclosure would be ‘taken the wrong way’:

“You kind of have to have to reach out for support, but you have to be optimistic...Its hard when you're struggling because if you're not optimistic they just take it the wrong way”

Another participant noted that the mental health systems that they used were only set up to deal with regular counselling appointments or ‘crisis’:

“the system can't accommodate [suicidal distress], it only is set up to deal with an immediate crisis”

Since suicidal distress to them was neither a regular counselling appointment or a ‘crisis’, they found that others they knew with suicidal feelings were forced to ‘manipulate’ the system to receive more immediate care as well as ‘perform’ a certain distressed role when working with service providers to be seen as ‘valid enough’ to receive care (and in turn experienced guilt for doing so):

“You have to say the magic 'suicide' word and then you can get an appointment. But if you don't say this word you're two weeks or 4 weeks or whatever...So now you have to sometimes make this more immediate to get in because you know that like its getting worse so you're, you're trying to be proactive... and then you feel bad because you feel as if you're over-reacting or you're just trying to get attention”

“the second you’re sitting in the doctor’s office, it feels like you have to perform in a certain way and if you're not performing you're not being authentic”

Conversely, participants spoke of navigating out of being considered ‘too suicidal’ by being cognizant of which ‘symptoms’ they were sharing (to avoid being seen as presenting too many) and be cautious of the ‘magic word’ ‘suicide’ (see above).

Notably, two participants did not address the process of navigating disclosure.

**Impact on Family and Friends.** Additionally, three of the four participants also considered the impact of their disclosure on family and friends before reaching out, if at all:

“I didn't wanna say anything to my little sisters... I didn't want them to like look at me and be like "Oh she can't handle...what's going on, maybe I shouldn't be able to either."

“I'm asking for my sister to be like, "Hey, like, can we, can you talk about a show," instead of calling her and being like “I'm like, the biggest waste of life...because if I wasn't me and I was someone else, I wouldn't want that for them”

“When I reach out I've told my mom and my brother that I've been thinking of killing myself, and it's a lot of emotional stress for them to go through”

Notably, one participant did not address family or friends in considering reaching out.

**Range of Responses.** When participants did reach out to either health care professionals, family, or friends, the range of responses included:

active listening:

“I felt like that was really helpful because she actually sat and listened”

empathy:

“she thought something's happening and so she was really empathetic”

providing support:

“its way more "thats really shitty. Is there anything I can do?" stuff like that. Like, "I'm here if you want anything". Offering like validation and support”

assistance in problem-solving:

“she helps out, she's understanding and tries to present other ways of looking at it and that sort of thing”

panic:

“[service providers] go "oh my God, are you gonna do this? We need to do this”

dismissal:

“when I told my doctor he actually laughed at me... and said "you're fine"

sanist remarks:

“I regretted that I did [reach out], because [she] has very I'm gonna say narrow-minded ideas of suicide, just because her words were that "it's pathetic". That someone would just end their life like that”

and ‘snapping’ (becoming angry in response to the disclosure):

“they sometimes snap in response”

Although most participants had some positive experiences ‘reaching out’, all participants experienced in some way the responses of panic and dismissal. In fact, two participants explained that health care providers had “one of two” reactions to disclosure, panic or dismissal:

“When I reach out to people, I get one of two reactions. So they go "oh my God, are you gonna do this? We need to do this” or its like "oh you're fine"

“There's kind of two options. They're convinced that I'm not going to hurt myself in the near future...or...I've lost a lot of rights”

Panic reactions looked like service providers:

failing to listen after the mention of the word ‘suicide’:

“once you say the word, its- they're not hearing anything else”

dramatizing the experience of the person with suicidal distress:

“I think the panic sometimes urgencizes, like makes it more immediate than it is”

narrowing the options to an intervention:

“People focus in on stopping a decision or intervention and like looking at it as a binary, living/dying kind of thing”

taking ownership of the person’s next steps:

“I think the second you say "I want to kill myself" or you say "I'm feeling suicidal" or you say these things, and you talk about suicidal distress um, people take this ownership over your course”

and questioning the competency of the person with suicidal distress:

“[they] were like, "oh, like are you okay, are you gonna be able to do this."”

Conversely, dismissive reactions looked like service providers, friends, or family: suggesting there is ‘no problem’:

“And you get them normally like, "Oh, Uh, you're so amazing like, what's the like, what's the problem?”

trying to change the topic:

“I have so many experiences with counsellors where I open my mouth and they're like "let's talk about something more productive”

ignoring the request for support:

“the one time I asked, nothing happens”

refusing to feel or display empathy for the person:

“I was just sitting there, like, and I don't know how he's not like even trying to understand”

and avoiding giving space for the person to tell their story/experience:

“They didn't even give me the chance to say my story or my experience, I don't think you can you can even begin to understand if you don't get the person to voice that”

This was especially hurtful to those participants who had been nervous about disclosure for fear of losing rights. For example, one participant stated:

“After all that time leading up to [asking for help], being fearful of people in authority, who do they report to, the one time I asked, nothing happens”

**Consequences of Negative Responses.** Along with sharing these various reactions, participants also suggested that the consequences of certain responses can be severe. Most upsettingly, one participant chose not to reach out again after being dismissed by service providers:

“So I was like- I'm never reaching out for help again”

Other consequences included internalized shame and sanism as well as ending the ‘reaching out’ encounter with no additional help, support, assistance, or care than before disclosure, as well as the threat of loss of rights (see above):

“Her words were that "its pathetic"...So, you know obviously made me feel like I internalized that”

“the one time I asked, nothing happens”

Two participants also noted a consequence of the ‘panic’ reaction is to both take responsibility from the person with suicidal distress but also move it away from the practitioner as well. One participant argued that after a mental health worker decides a person is ‘suicidal’:

“this now becomes how other people view my experience, as something they suddenly view as their responsibility. The second you say ‘I want to kill myself’...people take this ownership of your course”

Therefore, this participant saw this responsibility as leading to the practitioner having control over the next steps of the person deemed suicidal. Conversely, another participant saw the

‘panic’ reaction as moving the responsibility away from the service worker or others such as friends and family:

“it gives people a way to like not take responsibility”

**Criticism of Discourses – Biomedical.** In line with discussing the process and outcome of their disclosure, participants also spoke to me about the discourses, models, and lenses they encountered more broadly in their interactions with service providers, friends, and family. Most obviously, all participants addressed the biomedical model of suicidal distress, describing it as paternalistic, scary, interventionist, procedural, and narrowly focused on diagnosis:

“The [mad] focus is less on preventing a death or being paternalistic and interventionist....”

“I’m very aware that it’s “Okay is this a call to the hospital, is this something we can deal with this office, is there further action?”...What are the procedures?” Like thinking about it very procedurally”

“I don’t like how...they have to like find a diagnosis”

“If you’re here to help me I don’t want to be afraid of the help, and it just sounds, makes it scary.”

Additionally, participants suggested that a biomedical lens ignores the role of larger forces and social structures in creating distress, aims to quantify elusive feelings and experiences, and both dramatizes and villainizes people’s experience of suicidal distress:

“No one will actually say like, “the world is not working”. They’ll always say “oh something’s wrong with you”

“Both experiences are very very valid but neither of them is being taken into account in this kind of like quantifiable, like quantity-based system”

“This whole idea that we need to be qualified to listen to someone is I think really problematic and it leads to like a lot of "Oh no, this is a big thing"...making this so much more urgent. And like dramatizing this experience.”

“It made it sound like it was "trouble", like "you've done something wrong"”

Participants also felt mental health professionals following this model treat them like patients (as opposed to people), take control and ownership of both their life and experience, make them fearful and untrusting of the process of help, and try to fit them into the medical model instead of finding a model which works for their distress:

“That’s another thing about doctors, its like they treat you like you’re a patient...Not like a person but like more like just like the job kind of thing,”

“going to see [social services], its immediately them holding my experiences to what it means to them as opposed to like keeping it for me”

“If you're here to help me I don't want to be afraid of the help”

“we need to stray away from an idea where its just like "this is what’s gonna help".

Because in every situation, that one model isn't gonna help everyone”

Lastly, participants understood the ‘solutions’ inherent in the medical model as simplistic and unable to address underlying causes or longer-term issues:

“We can't keep putting money into like short term band-aid solutions when that’s not getting to the root of the problem”

“Not just have doctors forcing the latest pill on you is important. I think like that's just another ...band-aid solution, it doesn't really help address in my opinion. It should be...other ways to help you not feel that way anymore”



**Criticisms of Discourses – Professionalism.** Similar to the critiques concerning the biomedical model, three of the four participants also criticized the discourse of professionalism, finding it limited their capacity to express themselves. One participant in particular noted:

“if I want to like ball my eyes out or hug someone, I want to be able to do that”

These professional discourses were also critiqued for: suggesting that “we need to be qualified to listen to someone”, using the same model for vastly different circumstances and people (see above), and severely limiting the amount of time clients were able to talk with practitioners about their suicidal distress:

“there's like a protocol that you have to follow for your like suicide prevention...there's certain questions that you have to ask and you try to get them to commit to safety as fast as you can. And then if I can't like within a 5-minute conversation...I have to just send them to the hospital”

Importantly two participants also addressed the reality of neoliberalism and workplace hierarchy respectively, which they believed had an influence on the quality of professional services provided:

“Like everything just links back to neoliberalism!... it's all get them through these services quick and fast and easy”

“I personally think that if our world wasn't like a hierarchy like you can do this and this and I do this, then we wouldn't need to have mental health services”

Notably, one participant did not address the discourse of professionalism

**Criticism of Discourses- Awareness and Evidence-Based Practice.** Another model which two participants were cautious about was awareness initiatives, with one participant being critical of the way many awareness campaigns push medical and ‘talking’ models (which may

not work for everyone) and another participant questioning the usefulness of these campaigns for people in immediate suicidal distress:

“Like Bell Lets Talk, its all like "oh just talk about it" and like "talk about it its gonna be okay". Not for everyone...Or even just going to...get a psychiatrist...That won't work for everyone, it might work for some people, but not for everyone”

“when I'm feeling suicidal I...don't want to look at the internet and be like "oh, look at all this awareness. I want like, connection right there.”

Evidence-Based Practice (EBP) was another service model which was cited as unhelpful for suicidal distress. Two participants argued that not only does EBP prevent practitioners from “trusting themselves”, there also exists little solid evidence about what works for people with suicidal distress from which to base practice on:

“I find a lot of things are like very evidence based and what I'd really like is for people to trust themselves more.”

“We do rely on evidence based practice right now but its extremely dangerous because for something like suicide where there's maybe not that much evidence on all these different service modalities”

Notably, two participants did not discuss awareness campaigns or evidence-based practice.

### **Toward a Better Model of Practice**

More positively, participants addressed the kinds of responses which worked or would have worked for them when they reached out. These responses included:

active listening:

“having someone kind of be able to listen is so much more valuable”

“You need to listen to that and not...analyse like ‘oh just do this’

empathy:

“if there's someone who's like actually kind of showing empathy cuz I think for myself personally people showing that they care would be effective.”

“Operating within a truly accessible framework and a truly empathy-based framework has given so much more”

validation:

“Just someone to like validate what I was experiencing, like was real and was difficult and for someone to empathize with me because, or just give me credit for making it through”

support:

“offering like validation and support which I think is often times way more helpful than "here's the number of these 3 three counsellors you have to talk to right now"”

compassion:

“I actually felt like someone cared and wanted to listen and yeah, so that was helpful”

and a sense of connection:

“You can give me all the counselling services you want but what I really want is the connection”

Thus, these responses included friends, family or mental health workers ‘sitting and listening’, or ‘giving space’ to people to hear their story/experience, showing recognition that an individual’s struggles are real and difficult, as well as letting people talk or vent. As one participant put it:

“talking wouldn’t completely fix everything but I think that’s like the biggest starting point and the most important starting point”

In this way, there was a common consensus among participants that good care involved a humane and talk-focused response to suicidal distress. For one participant in particular, this response should be immediate to prevent people with suicidal distress from waiting for care:

“It needs to be like readily available”

In addition, participants also expressed ideas about discourses, models, and lenses which they believed would be most helpful for them or others like them if they were to reach out about suicidal distress:

- ***Humanizing Suicidal Distress***: Most interestingly, participants advocated for mental health care responses which ‘humanize’ suicidal distress, making it clear that feeling suicidal distress is ‘normal’:

“that just shows that you can be completely fine and you can have suicidal distress”

“like 'normalize' [suicidal distress], 'humanize' it sounds better. So just that people are comfortable so they don't have to let those thoughts fester to the point of where they actually take action”

Along similar lines, one participant suggested a more humble and helpful response to suicidal distress might involve a recognition that friends, family, and service providers may not be able to ‘fix’ or rid the person of the feelings, but instead be open to accepting ‘what’s happened’ and asking ‘how can I help?’:

“its that whole acceptance that they don't know if they can be helpful, they don't know, there's no security but there's also comfort, there's an acceptance of what's happened, "this is happening, this is bad, what can we do?”

- ***Asking “Why Not”***: Another idea proposed by a participant was for mental health staff, family, friends, and even society in general to avoid asking “why” someone is suicidal and

instead ask “why not”, which would encourage a deeper consideration of the struggles someone was facing, including the structural factors which shaped their life:

“I often think of suicide, instead of asking myself "why does this person feel this way", I ask "why not?" Cuz the the the structures are so messed up”

- **Cultural Sensitivity:** Also relevantly, one participant pushed for a cultural sensitivity model which understands all cultural medicines and healing practices as equally valid as well as encourages marginalized people to re-connect with their cultures:

“there should be...like cultural sensitivity training, people there who are aware of other methods that aren't all western medicines that sort of thing. To reconnect people to their cultures cuz for me that's personally important and its helped a lot.”

- **Community Model:** Additionally, an alternative model of mental health support based on a peer support or psychiatric survivor model was mentioned, in which suicidal distress is externalized and support is provided to respond to specific events and situations instead of diagnosis and symptoms:

“When I talk to other mad identified individuals or other survivors of suicide...it's less focused on like feeling and more on that trauma-informed or if there's something going on...more like how that other person can be there for me”

This model was explained as valuing lived experience in the practitioner as necessary to deliver good care, recognizing the importance of gaining agency and control in healing, and promoting the empowerment of mad/psychiatric survivor communities:

“communities of people with lived experience are indefinitely more valuable than a professional...because to me when I'm viewing these things as a response to

marginalization, as a response to regulation, as a response to control...things that are really really helpful are gaining back some control, gaining back some liberty”

“Communities of lived experience need to be empowered to care and support the individual”

**Other Models.** Other models mentioned by participants were narrative practices that truly considered the person with suicidal distress a person to learn from (as opposed to ‘changing the narrative’), imagining the counselling relationship as a ‘mutual sharing of emotions’, understanding responses to suicidal distress as a continuum of care, and working to understand someone’s full story and feelings before taking significant action:

“I think you have to be careful with narrative, its that you don’t try to change the narrative, because a lot of times like from what I’ve learned in [school], narrative is all about trying to create a story. No, this is the story - own it”

“the most memorable sessions with my counsellor have been the ones where its been a mutual sharing of emotions”

“like seeing suicidal stuff as a continuum of care”

“I don't think you can you can even begin to understand if you don't get the person to voice [their story]”

## **Discussion**

In aiming to explore what kinds of responses people are hoping to receive when they ‘reach out’ for help for suicidal distress, this thesis has uncovered a wealth of interesting data. Participants spoke about a number of different themes including how they understand their subjective experience of suicidal distress, the causes and aggravating factors associated with their suicidal distress, the experience of disclosing their feelings to others, the responses they received after disclosure, and the responses they prefer. These kinds of data have significant implications for both social work and suicide intervention theory and practice, providing insight into how participants experience their distress as well as raising questions about the effectiveness of current social work interventions. This chapter serves to summarize the study findings and compare these results to the literature, as well as detail limitations, suggestions for further research, and the potential for practical application.

### **Summary of Findings**

During the interviews, participants expressed a broad range of feelings, thoughts, and experiences regarding their suicidal distress. Importantly, participants understand their distress in some common ways. Most notably, participants defined suicidality as something ongoing, fluctuating, and in response to life events. These conceptions significantly challenge mental health notions of suicide as a ‘crisis’ state (Lewis & Robarts, 2001) as well as undermine the importance of psychopathology as a major factor (Canadian Association of Mental Health, 2011). Instead, participants suggested suicidality is shaped by both life stresses and structural and societal realities. Therefore, participants cited barriers associated with ablest environments, internalized homophobia, and lateral violence as examples of large-scale social realities which influence their

distress. In a similar way, participants also cited media as a discursive social tool which impacted their understanding of their distress. Importantly, in understanding suicidality as complex and context-dependent, participants also expressed criticism of current ideas about suicidal distress, such as the belief in an exterior pathological suicidality and a narrow view of recovery.

Along with discussing their conceptions of suicidality, participants also spoke about their experience disclosing their suicidal feelings with others. Importantly, participants noted that the choice to disclose is rarely straight-forward and that consequences exist for both silence and disclosure. While the need to reduce distress was a common reason for ‘reaching out’, the fear of losing friends or rights was instead a common concern for participants, often preventing them from disclosing. Additionally, for many participants, the impact that disclosure might have on family and friends was also a reason to remain silent. More than being knowledgeable about the potential consequences of disclosure, participants also expressed how they navigate mental health systems to straddle the boundaries between receiving care and avoiding a loss of their rights, such as using or avoiding certain words and being cognizant of organizational mandates and policies.

Relevant also to the experience of disclosure is the range of responses participants received when they did ‘reach out’, which includes active listening, empathy, providing support, assistance in problem-solving, panic, dismissal, sanist remarks, and becoming angry. Participants also addressed how these responses impacted their comfort with disclosing suicidal feelings in the future, such that the reaction of ‘dismissal’ prevented participants from feeling they could seek future help and reactions such as assistance with problem-solving caused participants to feel safe to disclose in future times of need.

The final set of data that the interviews produced involved participants voicing their suggestions for change in both the mental health system and suicide prevention responses. Most



significantly, participants stated the kinds of responses that they would prefer, which includes active listening, empathy, validation, support, compassion, and a sense of connection. Additionally, participants shared ideas for alternative ways of reacting to suicidal distress, such as humanizing suicidality, adopting multicultural frameworks, and implementing community models. These array of creative suggestions support responses which promote relationship-oriented and compassion and empathy-based frameworks more so than current interventions in suicide prevention.

### **Relation to the Literature**

The findings of this study both support some previous literature in the fields of suicidology, Mad Studies, and critical suicidology, but also challenge others. By thinking about the ways participants understand their suicidal distress and experience the disclosure process, as well as their suggestions for change in the mental health system, this section will serve to illustrate how these findings support and dispute the literature in the fields.

**Thinking about Suicide.** One of the most notable findings from this study is the common consensus among participants that suicidal distress is an ongoing and fluctuating experience. Unlike conceptions in mainstream mental health which view suicide as a discreet and contained crisis-state with a short duration and caused by psychopathy (Lewis & Robarts, 2001; Canadian Association of Mental Health, 2011), participants heavily emphasized the place of life experiences in creating their suicidality. Therefore, participants spoke about factors such as years of depression, extensive bullying in grade school, and facing constant inaccessibility as more relevant to their experience of distress than biological or psychological factors. In this way, participants define suicidal distress as a state which exists constantly but is heavily influenced by shifting life events.

Moreover, these life events are connected to broader social realities, such as oppressive conditions or histories of structural inequality.

Significantly, while not much of the literature addresses the ongoing nature of suicidal distress, there is clear consensus within Mad studies and critical suicidology that suicidality is a response based in life circumstances and societal structures (White, Marsh, Kral & Morris, 2016; Wexler & Gone, 2016; Menzies, LeFrancois & Reaume, 2013; Willis, Coombs, Cockerham, & Frison, 2002; Tousignant, Vitenti & Morin, 2013). Therefore, the results of this study correlate with other research which implicates social inequality and oppression in creating distress. For example, research has illustrated the relevance of colonial subjugation, racism, and transphobia among other social inequalities in creating the conditions which lead to poor mental health generally and suicide more specifically (Wexler & Gone, 2016; Tousignant, Vitenti & Morin, 2013; Walker, Salami, Carter & Flowers, 2014; Bauer, Pyne, Francino & Hammond, 2013; Willis, Coombs, Cockerham & Frison, 2002). In light of this literature, that participants point to ablest environments, internalized homophobia, and lateral violence (as a result of historic and ongoing colonial subjugation) continues to support a view of suicidality as shaped by macro-level forces to a great degree.

Another significant aspect of these findings is their challenge to suicidology literature which has endorsed a view of suicidal distress as discreet and individual (Lewis & Robarts, 2001; Canadian Association of Mental Health, 2011; Marsh, 2016). Participants problematize these understandings when they claim that they do not define their suicidal distress as short-term crises but instead feel distress fluctuating, as “something that comes and goes in intensity”. This challenge is particularly significant in thinking about social work practice, as current suicide intervention strategies almost always assume suicidality is a short-term, often pathological, state,

and therefore promote techniques such as signs and symptoms identification and assessment training (Lewis & Robarts, 2001; Canadian Association of Mental Health, 2011; LivingWorks Education, 2015). In these suicide prevention tactics, practitioners and lay people learn to recognize the ‘signs and symptoms’ of suicidality in a person and then promote short-term safety until the person is no longer ‘suicidal’ (LivingWorks Education, 2015; Lewis & Robarts, 2001). However, participants’ self-conception of a longer-term, context-based, and nuanced suicidal distress complicates these simple intervention strategies, suggesting that current suicide intervention techniques may be narrowing the experience of suicidality unnecessarily. Moreover, if only a fraction of the experience of suicidal distress is being responded to by current suicide intervention practices, this also has implications for how well current interventions can support distressed individuals.

In a similar way, participant understandings of suicidal distress also challenge suicide prevention strategies on the environmental level. There is significant literature on suicide prevention strategies targeting the public and public infrastructure, including public education, gatekeeper training, and means restrictions, such as rails on bridges or security around train tracks (World Health Organization, 2004; Mishara, 2007; Beautrais, 2007; White & Stoneman, 2012). While these strategies are extremely important in preventing some suicides, they also rest on assumptions that suicidality is a short-term, crisis-oriented state. Thus, the results of this study suggest a broader conception of suicidality could benefit these suicide prevention strategies as well.

Lastly, given the finding that media has an influence on participants understanding of their suicidal distress, this study correlates with other literature on the suicide prevention strategy of media censorship (Beautrais, 2007; Mishara, 2007; Leenaars & Wenckstern, 1999). Previous

literature has found media reporting of suicide attempts can lead to an increase in attempts of the same method in a population (Beautrais, 2007; Mishara, 2007; Leenaars & Wenckstern, 1999). Therefore, a common suicide prevention strategy on a social level is to limit the representation of suicide in news. Since the findings of this thesis have shown that participants feel that their self-conception of suicidal distress is influenced by media, this study can support this research in some ways. However, it must also be noted that participants addressed the impact of media representations more broadly, and advocated for discourse changes more than simply media censorship.

**Consequences to Disclosure.** Interestingly, this study uncovered findings about participants experience of disclosure which did not emerge in the literature on suicidal distress. While this thesis found that the decision to disclose was a complex and personal issue for participants, most literature explores the impact of public awareness of mental health and practice techniques on client's ability to disclose (Chambers et al, 2005; Tsai, Lin, Chang, Yu, & Chou, 2011; Gilmer et al., 2017). Therefore, most research on people's desire to disclose to mental health services has focused on the impact of stigma as well as cultural and language differences between clients and providers (Downs, 2012; Gilmer et al., 2017; Chu, Poon, Kwok, Leino & Goldblum, 2017; Blocker & Miller, 2013). In this way, while social work literature has determined some practice barriers which lead potential clients away from accessing mental health services, there has been less discussion about people's dynamic and personal reasons for using and avoiding suicide intervention resources. Therefore, this study provides findings which enhance this discussion by considering the broader reasons why people may choose to use or avoid suicide prevention services.

In particular, participants expressed nervousness about losing friends and social networks they rely on, adding depth to other studies which explore the impact of stigma on people's decision to disclose (Blocker & Miller, 2013; Downs, 2012), but also confirming the reality of sanism as an oppression that subtly shapes people's access to resources and limits choices (Kalinowski & Risser, 2000; Poole et. al, 2012). More soberly, participants' complex decisions about whether to disclose also connects with research illuminating the capacity of mental health systems to dehumanize and abuse mad people as well as the impact of losing civil rights as a result of being deemed suicidal (Kalinowski & Risser, 2000; Warne, 2013; O'Hagan, 2016). That participants must navigate suicide prevention and intervention services in such a way as to avoid these undesired outcomes is an incredibly important finding as it illustrates the negative impact of suicide prevention policies on those who reach out, as well as raises questions about the effectiveness of a mental health system that clients do not fully trust.

Another relevant finding concerning participants' decision to 'reach out' or not 'reach out' is the extent to which participants considered the impact on family and friends. Significantly, most participants expressed a concern for the wellbeing of both family and friends as a factor preventing them from sharing their distress. Given how sparse the literature is regarding this aspect of disclosure, this study provides important beginning research.

Along with findings related to decisions about disclosure, this study also discovered results regarding the kinds of responses participants received when they did disclose, such as active listening, empathy, assistance in problem-solving, panic, dismissal, sanist remarks, and becoming angry. This range of responses correlates with other research regarding service provider responses to mental health patients as well as first person accounts by those who have used mental health services (Hughes, Hayward & Finlay, 2009; Shaw, 2016; Webb, 2010; Chamberlain, 1979).

Therefore, this research builds on previous literature which details the array of experiences people have after they disclose, both negative and positive. Importantly however, this study also found that, among the responses participants did receive, all participants had experienced the responses of panic and dismissal. Although not noted in previous studies, this finding is significant in understanding the reality of the mental health system as it is experienced by those who use it. Additionally, that these responses emerge as common amongst all four participants suggests these two responses play a significant role in the process of suicide intervention services.

In regards to these two responses, participants were cognizant of how suicide intervention policy encourages mental health workers to respond with either dismissal or panic. One participant shared how a person's suicidal distress is deemed either 'valid enough' or not, resulting in a practitioner 'going on alert' and prioritizing a safety scheme or dismissing the suicidal distress as insufficient to warrant significant care. Here, participants address the tendency of suicide intervention strategies to focus on 'safety' above all else, with safety being defined as prevention from physical lethality (LivingWorks Education, 2015). Moreover, participants were cognizant of how suicide assessments are often rigid, numerically-based measurements which account for only certain kinds of distress (eg, visible signs and symptoms). These findings from participants are valuable to provide insight into how suicide intervention policy shapes the way practitioners respond to clients in distress.

A final finding in relation to the responses of panic and dismissal is the negotiation of responsibility amongst service providers. Participants shared how suicide intervention services require service providers to take responsibility over the participant, yet also offload responsibility to other staff, such as hospital or crisis workers. In this way, participants felt their dignity was denied as they no longer had control over their own decisions, in addition to feeling that some

workers were ignoring their request for support by shifting responsibility somewhere else. Although this was a major finding in the study, it is unique amongst literature in this subject. Moreover, this finding ore theorizing could be done to examine the process of suicide interventions, especially in regards to their impact on client care.

**Thinking about Change.** The last set of findings explore participants' ideas about change in suicide prevention services. Therefore, these findings contribute to a wider body of literature which aims to promote lived experience as a basis for theorizing and evaluating mental health responses (Hjelmeland, 2016; LeFrancios, 2016; Webb, 2016; Shaw, 2016; Sweeny, 2016; Beresford, 2016). Previous work has established that clients prefer mental health care which is safe, comfortable, supportive, understanding, autonomous, respectful, and holistic (Agar-Jacomb & Read, 2009). Other literature has exemplified the importance of attentive listening and compassion for mental health issues such as self-harm and suicidal distress (Shaw, 2016; Webb, 2016; Coveney, Pollock, Armstrong & Moore, 2012). In this way, that participants state that their preferred responses are active listening, empathy, validation, support, compassion, and connection supports this previous research. Additionally, these findings also enhances literature which argues for privileging people's subjective distress over medicalized symptoms (Webb, 2010; Shaw, 2016).

Additionally, the finding of participants preferred responses also has implications for both social work and suicide intervention practices. That participants promote talk-focused, compassion-oriented, and relationship-based methods of responding to suicidal distress aligns with certain previous research and problematizes others. Again, these findings challenge mainstream suicide prevention and intervention techniques, such as crisis assessment, safety planning, and gatekeeper training, suggesting these techniques fail to address the broader needs of people with

suicidal distress to speak and be heard. These findings also suggest that society-level suicide prevention practices such as public awareness and means restriction are limited in their scope to affect change in suicide rates without also being paired with ground level talk-focused, relationship-oriented techniques.

While these findings challenge more mainstream approaches, they also give weight to relationship-oriented practices. Most notably, these preferred responses promote talk-based therapies and propose that even crisis services should include a significant talk (and being heard) aspect. Moreover, given the finding that participants experience suicidal distress as a long-term experience, this finding might also encourage an increase in talk-based therapies in general, for more than simply suicidal distress. Additionally, apart from supporting talk-based therapies, these preferred responses also allude to the significance of mutual peer support as well as mad practices such as respite centers, as these practices are rooted in a desire for compassionate care and attentive listening (Filson & Mead, 2016; Starkman, 2013). In this way, these findings have significant implications for how suicide intervention strategies can best serve the needs of those in distress.

Apart from sharing their preferred responses, participants also provided ideas about alternative models for responding to people with suicidality. These alternative models include humanizing suicidal distress, asking ‘why not’ instead of ‘why’ (someone is suicidal), including cultural sensitivity into practice, and adopting community models. Interestingly, all of these ideas also raise questions about the effectiveness of those suicide intervention techniques based on assumptions of suicidal distress as discreet, momentary, and caused by psychopathology (Lewis & Robarts, 2001; Canadian Association of Mental Health, 2011; LivingWorks Education, 2015) as they move beyond these limited frameworks to discuss the broader reality of suicidal distress. In fact, these ideas from participants connect with research on the wider nature of suicidal distress



as well as responses on the macro level (Shaw, 2016; Rees, 1999; Trevithick, 2014; Webb, 2010; Liegghio, 2013; Kalinowski & Risser, 2000; Poole et al, 2012; Walker, Salami, Carter & Flowers, 2014; Bauer, Pyne, Francino & Hammond, 2013; Wexler & Gone, 2016; Tousignant, Vitenti, & Morin, 2013; Willis, Coombs, Cockerham & Frison, 2002).

In promoting the humanizing of suicidal distress, participants connect with previous literature on the vital importance of being seen as human when in distress (Liegghio, 2013; Shaw, 2016; Rees, 1999; Trevithick, 2014). In a similar way, previous literature also argues for the importance of witnessing human experiences (such as suicidal distress) without pathologizing or limiting the feelings to a biomedical or psychiatric phenomenon (Webb, 2010). Therefore, this alternative model in particular aligns with previous research on the importance of witnessing humanhood and distress respectfully, an aspect of suicide intervention rarely discussed in mainstream literature. The alternative model of ‘asking why not’ (or why someone *wouldn’t* be suicidal) also aligns with the literature as it encourages practitioners to think more deeply about the struggles and challenges people with suicidal distress might be facing, therefore opening up the possibility for more honest witnessing. Importantly, the process of asking ‘why not’ might also have implications for critical social work and suicide intervention strategies as it has potential to address structural and anti-oppressive understandings of people’s distress. Therefore, this finding also aligns with literature on the structural causes of distress (Kalinowski & Risser, 2000; Poole et al, 2012; Walker, Salami, Carter & Flowers, 2014; Bauer, Pyne, Francino & Hammond, 2013; Wexler & Gone, 2016; Tousignant, Vitenti, & Morin, 2013; Willis, Coombs, Cockerham & Frison, 2002).

Additionally, the alternative model of cultural sensitivity is heavily supported in social work literature (Hogan, 2012; Sue, Rasheed & Rasheed, 2016; Garcia & Van Soest, 2006).

Moreover, participants specify that cultural sensitivity should promote all cultural healing *equally*, with marginalized healing methods considered as important as Western medicines. Again, this alternative model heavily challenges mainstream suicide intervention methods to consider its limitations and where other models might provide more comprehensive or holistic care.

Lastly, the participant suggestion of community models aligns with literature on Mad alternatives to biomedical psychiatry (Chamberlain, 1979; Mead & Filson, 2016; Starkman, 2013; Dos Santos & Beavan, 2015). Here, participants speak to the possibility of having a community of those with lived experience support and nurture one another, away from medicalized or psychologized spaces. In this way, this model has close resemblance to intentional peer support (Filson & Mead, 2016), as well as current mad practices of community support (Mad Student Society, n.d.). Thus, this model has significant implications for social work practice as it promotes the need for communities of people with lived experience to have a major and valuable place in the mental health complex (LeFrancios, 2016; Webb, 2016; Hjelmeland, 2016; Sweeny, 2016).

## **Limitations**

There are some limitations to this study. Firstly, the small sample size makes this study impossible to generalize. Because of the short time-frame given to write this thesis, only four participants were chosen to provide data. Therefore, a much larger study would be needed to ensure these results are generalizable. Furthermore, the study participants were limited to those who were currently students at McMaster university. In this way, the study is also limited in its ability to theorize beyond the student demographic.

Additionally, this thesis did not consider in-depth the possibility of intersecting identities on experiences of suicidal distress. Therefore, although all participants did experience multiple

marginalities, this study is limited in theorizing what participants are looking for when they ‘reach out’ for help as it relates to differences across identities.

### **Future Research**

Given the results of this study, future research should explore how suicide intervention services could implement a philosophy which recognizes the broader experience of suicidal distress, including its long-term aspects. Understanding how suicidal distress can be re-imagined in a more holistic way within these services would be vital to contributing to positive change in the mental health system. Additional research could also replicate this study with other populations, to determine if these results are generalizable.

### **Implications for Practice and Policy**

**Practice.** The results of this study have some implications for both social work and suicide prevention and intervention practice. Most obviously, participants state they prefer certain responses to their disclosure of suicide distress, including active listening, empathy, validation, support, compassion, and connection. Moreover, the findings illustrate that these ways of reacting to those with suicidal distress promotes better care and also increases the likelihood that those clients will reach out again in future times of need. Fortunately, social workers as a profession value these same kinds of responses and therefore many practitioners hold skills in this area.

However, although social work and suicide intervention work does promote these forms of responses in theory and some practice (Miller, 2012; LivingWorks Education, 2015), the findings of this thesis illuminate how suicide intervention techniques often fail to give space for privileging attentive listening, empathy, and compassion. As participants have noted, the focus on ‘safety’ and attaining a safety plan often takes precedent over ‘sitting and listening’. In this way, the more relationship-oriented and compassion-based techniques are forgotten as attention is turned towards

controlling the possibility of lethality. Significantly, participants note that this narrowing of the concern only to lethality creates a nervousness around disclosure. In fact, the fear of what will happen after disclosure, especially the concern around loss of rights, prevented some participants from reaching out in times of distress. Therefore, these findings should encourage practitioners to be cautious of the need to control lethality above maintaining an empathetic relationship with clients in distress. In addition, practitioners could benefit from being conscious of the ways that safety planning and crisis assessments serve to draw attention away from responses such as active listening, empathy, and compassion and resist valuing these procedures over providing empathetic care.

**Policy.** As well as implications for social work and suicide intervention practice, this study also has implications for policy. Importantly, the results of this study show that participants understand suicidal distress as a long-term experience which fluctuates based on life events. Therefore, this conception challenges policymakers to move beyond imagining suicidal distress as an individual, decontextualize, and purely pathological issue to recognize the holistic, as well as structurally influenced, causes for suicidality. Thus, the findings of this study suggest that current mainstream suicide prevention practices, including crisis assessments, hospitalizations, gatekeeper training, and means restrictions, only address a portion of the reasons for distress. Instead, broadening the understanding of suicidality to include ongoing adverse life circumstances as well as social oppression and inequality opens the possibility to recognize a wider range of suicide prevention tactics. Most notably, these results stress the importance of supporting genuine long-term talk-therapy, which would give clients the space to talk and ‘be heard’. Other possible suicide prevention tactics could include allying with social justice organizations to alleviate the social inequalities which structure a reality of distress for marginalized people.

## **Conclusion**

This thesis has sought to explore the kinds of responses people are looking for when they disclose their suicidal distress to others, using a qualitative method of interviewing people with lived experience of suicidality. In doing so, a host of findings were uncovered about people's experience of suicidal distress and disclosure, and ideas for mental health change. These findings are significant as they both align with as well as challenge previous research and literature in suicidology studies, Mad studies, and critical suicidology. Additionally, these findings have major implications for both suicide intervention practice and policy.

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## **Appendix A**

### **Email Recruitment Script**

**Amy Rector, BSW,**

**Masters Candidate in Social Work**

### **A Study of Suicide Prevention and Lived Experiences of Suicidal Distress**

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**E-mail Subject line:** McMaster Study – Suicide Prevention and Lived Experience(s) of Suicidal Distress.

Hello,

I am a Master's of Social Work student at McMaster University who is looking for people with lived experience(s) of suicidal distress to participate in a 1 hour long interview as part of a study on Suicide Prevention and Lived Experience of Suicidal Distress. This study aims to (a) understand how people with experiences of suicidal distress comprehend these experiences and (b) discover how people with experiences of suicidal distress would change suicide prevention practices if they could.

There are some potential risks to being in this study, specifically the risk of feeling badly or distressed as a result of discussing your experience(s) of suicidal distress. To reduce the level of this risk, debriefing counselling from Student Wellness Center is being offered immediately after the interview.

You can stop being in this study any time during the interview or and afterwards up to June 1 2017. I have attached a copy of a letter of information about the study that gives you full details. This study has been reviewed and cleared by the McMaster Research Ethics Board. If you any have concerns or questions about your rights as a participant or about the way the study is being conducted you can contact:

The McMaster Research Ethics Board Secretariat

Telephone: (905) 525-9140 ext. 23142

c/o Research Office for Administration, Development and Support (ROADS)

E-mail: [ethicsoffice@mcmaster.ca](mailto:ethicsoffice@mcmaster.ca)

Thank you in advance for your time and consideration. If interested in participating, please email me at [Rectora@Mcmaster.ca](mailto:Rectora@Mcmaster.ca).

**Amy Rector** BSW,

Masters Candidate in Social Work

School of Social Work,

McMaster University, Hamilton Ontario

[Rectora@mcmaster.ca](mailto:Rectora@mcmaster.ca)





Appendix B: Recruitment Poster  
PARTICIPANTS NEEDED FOR  
STUDY ON Suicide Prevention and Lived Experience of Suicidal Distress

We are looking for volunteers to take part in a study of Suicide Prevention and Lived Experience of Suicidal Distress.

You would be asked to participate in a 1 hour long interview regarding:

- How you understand your experience(s) of suicidal distress
- What changes you would like to see made to suicide response systems (eg. crisis lines, hospital services)

For more information about this study, or to volunteer for this study,  
please contact:

*Amy Rector*

*Masters of Social Work Student*

*Department of Social Work, McMaster University*

Email: *Rectora@McMaster.ca*

**This study has been reviewed by, and received ethics clearance  
by the McMaster Research Ethics Board.**

Amy Rector  
M.S.W. Student  
[Rectora@mcmaster.ca](mailto:Rectora@mcmaster.ca)

Amy Rector  
M.S.W. Student  
[Rectora@mcmaster.ca](mailto:Rectora@mcmaster.ca)

Amy Rector  
M.S.W. Student  
[Rectora@mcmaster.ca](mailto:Rectora@mcmaster.ca)

Amy Rector  
M.S.W. Student  
[Rectora@mcmaster.ca](mailto:Rectora@mcmaster.ca)

Amy Rector  
M.S.W. Student  
[Rectora@mcmaster.ca](mailto:Rectora@mcmaster.ca)

Amy Rector  
M.S.W. Student  
[Rectora@mcmaster.ca](mailto:Rectora@mcmaster.ca)

# Appendix C

## *Interview Questions*

### **Suicide Prevention and Lived Experience of Suicidal Distress**

Amy Rector, MSW Student

(School of Social Work – McMaster University)

**Information about these interview questions:** This gives you an idea what I would like to learn from you. Interviews will be one-to-one and will be open-ended (not just “yes or no” answers). Because of this, the exact wording may change a little. Sometimes I will use other short questions to make sure I understand what you told me or if I need more information when we are talking such as: “*So, you are saying that ...?*”), to get more information (“*Please tell me more?*”), or to learn what you think or feel about something (“*Why do you think that is...?*”).

#### **Experience**

**In this section, I will ask you about your experience of feeling suicidal distress as well as your experience of ‘reaching out’ to others, or not. I am hoping to get a sense of how you personally experienced being distressed, reaching out, and articulating your needs.**

**1) Can you tell me a little bit about your experience(s) of suicidal distress? (Such as: how were you feeling? What were you thinking at the time? How did you respond to this experience in the moment?) Please feel free to say as little or as much as you’d like to.**

**2) Did you reach out to anyone when you were in distress? [ ☐ Yes [ ☐ No.**

**If yes, how did you express yourself to someone else/other people? What words, phrases, and metaphors did you use?**

**If no, what was your reasoning for not reaching out?**

**3) In your opinion, how did the people you reached out to understand your distress? Did their understanding of your distress differ from yours or do you feel they understood how you felt?**

**4) When you reached out to someone else/others for help, what kind of response were you hoping for? What did you need at that moment?**

### **Alternatives**

**For this next set of questions, I am hoping to find your opinion on how we might improve or imagine alternatives to current suicide prevention strategies.**

**5) Is there anything you would change about your previous encounter(s) with suicide prevention work? Do you have any feedback on the way you were treated (eg. speed of service, respect for your autonomy and choice, effective actions, effectiveness of actions taken for *after* crisis ended)? Is there anything you especially appreciated about the service provided or the people who attended to you?**

**6) Do you have any suggestions for change for suicide prevention responses in general (eg, hours of operation, accessibility concerns, language and metaphors used, etc.)? Is there anything you like, that you definitely wouldn't change about current suicide prevention responses?**

**7) In your opinion, what would an ideal suicide prevention system look like? Where would it exist (online, over telephone, in a physical space)? Who would the staff be? What kinds of services would be offered (such as referrals to housing centers, long -term counselling)? What methods would it use to best respond to your needs?**

**8) Did I miss anything? Is there anything else you think I should know?**

DATE: Jan. 29 2017

## APPENDIX D

### LETTER OF INFORMATION / CONSENT

#### A Study of/about Suicide Prevention and Lived Experience of Suicidal Distress

**Student Investigator:**

Amy Rector  
School of Social Work  
McMaster University  
Hamilton, Ontario, Canada  
Email: [Rectora@mcmaster.ca](mailto:Rectora@mcmaster.ca)

**Faculty Supervisor:**

Dr. Ameil Joseph  
School of Social Work  
McMaster University  
Hamilton, Ontario, Canada  
Email: [Ameilj@mcmaster.ca](mailto:Ameilj@mcmaster.ca)

**Purpose of the Study:**

The purpose of this study is to explore the way people with experiences of suicidal distress\* felt about their encounters with or avoidance of mental health, suicide prevention, or social work services and what changes they would like to see made to suicide prevention services. These changes could be practical changes (such as suggestions about hours of operation or accessibility concerns), more theoretical changes (such as adopting a recovery or mindfulness response model), or discursive and large-scale changes (such as creating alternatives which use a peer support model, or addressing poverty/racism/sexism etc. as a suicide prevention response), or any other relevant changes. Through pondering the responses received from participants, the study hopes to develop new insights into the needs, hopes, and desires of people facing suicidal distress and encourage change in suicide prevention and mental health services which are more appropriate and responsive to the people they intend to serve.

\* Suicidal Distress refers to any unpleasant and/or intense feelings related to the idea of personally committing suicide, whether experienced for a short or long time.

\*\* It should be noted that this study is being conducted as part of a Masters of Social Work degree.

**Procedures involved in the Research:**

If you agree to participate, you will be asked to take part in a 45-60 minute one-to-one\* interview in which I will ask you 7 questions. With your permission, the interview will be audio recorded. Additionally, (again, with your permission), I may take some notes to help me remember key information and sort my thoughts while we talk.

The questions I will ask you are as follows:

- 1) Can you tell me a little bit about your experience(s) of suicidal distress? (Such as: how were you feeling? What were you thinking at the time? How did you respond to this experience in the moment?) Please feel free to say as little or as much as you'd like to.
- 2) Did you reach out to anyone when you were in distress? [ ☐ ] Yes [ ☐ ] No.  
If yes, how did you express yourself to someone else/other people? What words, phrases, and metaphors did you use?  
If no, what was your reasoning for not reaching out?
- 3) In your opinion, how did the people you reached out to understand your distress? Did their understanding of your distress differ from yours?
- 4) When you reached out to someone else/others for help, what kind of response were you hoping for? What did you need at that moment?
- 5) Is there anything you would change about your previous encounter(s) with suicide prevention work? Do you have any feedback on the way you were treated (eg. speed of service, respect for your autonomy and choice, effective actions, effectiveness of actions taken for after crisis ended)?
- 6) Do you have any suggestions for change for suicide prevention responses in general (eg, hours of operation, accessibility concerns, language and metaphors used, etc.)?
- 7) In your opinion, what would an ideal suicide prevention system look like? Where would it exist (online, over telephone, in a physical space)? Who would the staff be? What kinds of services would be offered (such as referrals to housing centers, long -term counselling)? What methods would it use to best respond to your needs?
- 6) Did I miss anything? Is there anything else you think I should know?

\* One-to-one means that only you and I will be present at the interview (as opposed to a focus group, in which a researcher interviews 4-5 people at once).

### **Are there any risks to doing this study?**

There are some risks to doing this study. They are as follows:

*Possibility of feeling distressed:* Since I will ask you about experiences of suicidal distress, you may remember your past feelings and experiences and feel badly while we are talking. Also, you may feel okay at the time but feel badly later on in the day or week in remembering our discussion. To prepare for this possibility, the Student Wellness Center at McMaster University has agreed to have counsellors available after our discussion for debriefing. In other words, if you feel badly/are triggered during or after our discussion, you have the opportunity to talk with a counsellor right away. As well, Student Wellness Center will be available to you in the weeks after our discussion to give you support if you need it. In other words, if you are feeling badly/triggered in the weeks after our discussion, you can contact Student Wellness Center to speak with a counsellor.

\*Please note that regarding the debriefing services, Student Wellness Center may contact you for follow up if you have expressed a desire to talk with someone.

Additionally, please be aware that you do not need to answer questions that you do not want to answer or that make you feel uncomfortable.

### **Are there any benefits to doing this study?**

Chances are, the research will not benefit you directly. However, the possible benefits are as follows:

*Opportunity to express your views on the topic of suicide prevention:* Possibly, the opportunity to express your experience with suicidal distress, your encounters with suicide prevention services, and your opinion on the idea of changing current suicide prevention models may make you hopeful, happy, and/or motivated.

*Possibility of influencing changes to suicide prevention models:* This research has the potential to influence current models of suicide prevention by suggesting changes that could be taken up to improve services, or create new ones. Additionally, this research could potentially serve as a support in advocacy efforts to create changes to current mental health systems.

### **Confidentiality**

Your participation in this study is confidential. This means your name or any identifying information about you will not be used in any material produced from the interview, such as the thesis or journal articles (unless you would prefer to be named). Instead, a false name or a number (such as participant #2) will be used. Any information about you (such as the transcript of the interview or notes that concern your information) will be password protected on my computer that only I have access to. Any paper files (such as my notes) and audio material will be kept in a locked file where only I have access to it.

The information you provide to me will be kept for 2 years, which gives me time to publish the results of the study. At that time, it will be destroyed.

### **b) Legally Required Disclosure:**

I will protect your privacy as outlined above. If legal authorities request the information you have provided, I will defend its confidentiality.

### **What if I change my mind about being in the study?**

If you decide to be part of this study, you can withdraw from the interview for whatever reason, even after signing the consent form or part-way through the interview. If you decide to withdraw, there will be no consequences to you. In cases of withdrawal, any data you have provided will be destroyed (unless you indicate otherwise) before June 7 2017.

If you do not want to answer some of the questions you do not have to, but you can still be in the study.

### **Information about the Study Results:**

I expect to have this study completed by approximately September 2017. If you would like a brief summary of the results, please let me know how you would like it sent to you (email or mail).

### **Questions About the Study:**

If you have any questions or need more information about the study itself, please contact me at:

*Amy Rector, BSW,  
Masters of Social Work Candidate  
School of Social Work  
McMaster University  
Rectora@mcmaster.ca*

**Or**

*Ameil Joseph  
Assistant Professor  
School of Social Work  
McMaster University  
(905)-525-9140 ext. 23792*

This study has been reviewed by the McMaster University Research Ethics Board and received ethics clearance. If you have concerns or questions about your rights as a participant or about the way the study is conducted, please contact:

McMaster Research Ethics Secretariat  
Telephone: (905) 525-9140 ext. 23142  
C/o Research Office for Administrative Development and Support  
E-mail: [ethicsoffice@mcmaster.ca](mailto:ethicsoffice@mcmaster.ca)

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### CONSENT

- I have read the information presented in the information letter about a study being conducted by Amy Rector of McMaster University.
- I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.
- I understand that if I agree to participate in this study, I may withdraw from the study at any time or up until **June 7 2017**.
- I have been given a copy of this form.
- I agree to participate in the study.
- I agree that the interview can be audio recorded.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Participant (Printed) \_\_\_\_\_

1. I would like to receive a summary of the study's results.

Yes. Please send them to me at this email address \_\_\_\_\_

Or to this mailing address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

No, I do not want to receive a summary of the study's results.